INDEX

CITATIONS

Cases:

IN THE

Supreme Court of the United States

OCTOBER TERM, 1970

No. 108

ELLIOT L. RICHARDSON, Secretary of Health, Education and Welfare,

Petitioner,

v.

PEDRO PERALES

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF OF AMICI CURIAE ON BEHALF OF RESPONDENT

STATEMENT OF INTEREST

Appalachian Research & Defense Fund, Legal Research for Appalachian Elderly, and the Center on Social Welfare Policy and Law have obtained the written consent of both Petitioner and Respondent to file an amici curiae brief as required by Supreme Court Rule 42(2), such written consents having been duly filed with the Clerk of Court.

Legal Research For Appalachian Elderly and the Legal Services for the Elderly Poor Project of the Center on Social Welfare Policy and Law are legal services programs funded by the Office of Economic Opportunity and sponsored by the National Council of Senior Citizens. The purpose of these programs is to develop and advance ways for our legal system to respond to the needs of the low income elderly. Appalachian Research & Defense Fund is also a legal services program funded by the Office of Economic Opportunity.

Appalachian Research & Defense Fund and Legal Research For Appalachian Elderly are located in the coal mining regions of eastern Kentucky and southern West Virginia and represent persons who have become disabled as the result of industrial accidents and disease. Both projects are especially concerned with the stringent medical evidence requirements imposed in the administration of the Disability Insurance Benefits program. The Center on Social Welfare Policy and Law is a specialized law reform unit of the Legal Services program of the Office of Economic Opportunity. Affiliated with the Columbia University School of Law, the Center's Legal Services for the Elderly Poor undertakes research pertaining to the legal rights of the elderly poor. Because of the impact on the elderly poor of the Disability Insurance Benefits program, the Elderly program has a vital interest in presenting to this court the full range of issues raised by this case.

SUMMARY OF ARGUMENT

Numerous persons in Appalachia and other regions who can no longer work are denied Disability Insurance Benefits for failure to satisfy the burden of proving they are "totally disabled" due to any "medically determinable physical or mental impairment." 42 U.S.C. 423(d)(1).

In the instant case Pedro Perales was denied disability benefits because, among other things, there was "no objective neurological evidence" that he was suffering from a herniated disc, diagnosed by his family doctor, which caused the pain and limitation of motion he claimed was keeping him from resuming his employment. Accordingly, whatever impairment he had could not be proved to be of the required severity by "objective" neurological evidence.

It is the position of *amici* that there is adequate evidence to prove that Respondent's disc problem is "medically determinable," and that "medically determinable" does not mean that disability can only be proven by "objective evi-

dence"; rather, this language requires that there be medical verification of the fact that the claimant is suffering from a condition (or conditions) recognized by the healing art, whether that condition be proven by the most "objective" testing procedure known to medicine or by the most subjective but clinically recognized symptoms uttered by the patient.

The procedure followed by the Secretary in the regulations and in this case is representative of the practice of the Secretary to rely, contrary to 42 U.S.C. § 423(d)(1), almost exclusively on written medical evidence (especially "objective" reports of laboratory or medical tests or specialists' examinations) and to give little or no consideration to reports or testimony by the claimant's own treating doctor or to the claimant's own account of his functional loss.

The immediate issue in this case is whether written medical reports are inherently reliable and probative so that they may constitute substantial evidence without requested cross examination. In this case, the "objective" reports of myelographic and electromyographic examinations, which were the basis of the denial of claim for benefits, demand explanation, particularly in light of Respondent's family doctor's insistence on the bona fides and objective basis of Respondent's complaint. Cross-examination of the authors of the objected-to reports is necessary to establish among other things: the manner of interpretation applied by each to the objective test results; the reliability and significance of the test results; and the weight to be given the test results in relation to testimony of the claimant's treating physician.

By urging the inherent reliability and probative value of written "objective" reports, the Government seeks to gain approval of its requirement of "objective" medical evidence for disability determinations. Such a requirement of "objective" evidence is improper for three reasons. It is not statutorily authorized. The significance and weight of medical reports reflecting objective testing procedure are not

constant or apparent on the face of the reports but must be determined in each case. Finally, the "objective evidence" standard emphasizes the kind of evidence most difficult for the claimant to obtain, analyze and rebut, and thereby imposes an undue burden of proof upon the claimant.

ARGUMENT

I. WRITTEN MEDICAL REPORTS CANNOT, IN THE CONTEXT OF A DISABILITY DETERMINATION, BE SAID TO BE SO RELIABLE AND PROBATIVE AS TO CONSTITUTE SUBSTANTIAL EVIDENCE WITHOUT REQUESTED CROSS-EXAMINATION.

A. Written medical reports reflecting "objective" testing procedures are not by themselves reliable and probative.[1]

The Government contends that written medical reports, especially those containing the results of objective tests, are inherently reliable and probative. The Government argues further that such objective findings, although submitted in written form without the opportunity for cross-examination, are sufficient proof on the ultimate issue of disability.

Cross-examination of the specialists in the present case who performed objective tests was needed to establish the limited independent value of such tests, to explore the results of the tests in light of the diagnosis of claimant's treating physician, and to establish that a treating physician who has had the opportunity to see the patient over a long period of time is in a superior position to make judgments regarding the patient's condition.[2]

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[1]The valuable assistance of John Betinis, M.D., as medical consultant for this portion of the brief is gratefully acknowledged.

[2]*Combs v. Gardner*, 382 F.2d 949, 956 (6th Cir. 1967); *Helsep v. Celebrezze*, 356 F.2d 891, 894 (4th Cir. 1966); *Celebrezze v. Walter*, 346 F.2d 156 (5th Cir. 1965); and *Hayes v. Gardner*, 376 F.2d 517, 521 (4th Cir. 1967).

1. *The results of objective tests are necessarily subject to various interpretations, both as to their meaning and as to the significance of their meaning in terms of the physical or mental impairment the disability benefit claimant contends precludes him from employment.*

Two objective tests, a myelogram and an electromyogram (EMG), were performed on the claimant in the present case. Both tests were authorized by the Administration in an attempt to substantiate Dr. Morales' general diagnosis of slipped disc and determine objectively the basis for claimant's complaints of pain and limitation of motion. The results of both tests were relied on heavily by the hearing examiner.

The results of these laboratory tests, by themselves, are not meaningful in determining "the question of impairment or to the ultimate question of inability to engage in substantial gainful activity. A myelogram reveals only irregularities in the shape and symmetry of the space surrounding the spinal cord, and the readings of an electromyelogram merely describe the irregularity or regularity of electrical activity in muscles tested during rest and exertion."[3] These readings, insofar as they are merely recorded,

[3]The intervertebral disc itself is soft tissue and accordingly will not show up on an x-ray, so the disc itself cannot be x-rayed. However, any irregularity that the protruding disc may cause in the shape of the fluid sac (subarachnoid space) surrounding the spinal cord or irregularities in the slight bulges in the fluid sac caused by the nerves leaving the sac (nerve sleeves) may be visualized on x-ray film if the shape of the sac can be visualized. The fluid sac is also soft tissue which will not show up on x-ray, but, it can be filled with radio opaque fluid injected into the fluid sac and on x-ray the radio opaque fluid will outline the shape of the fluid sac. Gelfand, Magna, Merliss, *The Low Back*, sec. 24.00 (1970).

The EMG measures electrical activity produced by individual contracting muscle fibers. One motor nerve supplies each motor unit, and each motor unit in turn supplies a number of muscle fibers. Each muscle is controlled by several motor units, with the larger muscles such as were being tested in Mr. Perales being controlled by

are "objective."[4] But once they are necessarily interpreted, the readings lose their "objectivity."[5]

Cross-examination of the doctors who performed the objective tests is necessary, in this case, to establish exactly what the myelogram[6] and electromyogram readings were and the significance of these findings on the question of

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several hundred or thousand motor units. The EMG tests the workings of *individual* motor units by taking readings of the electrical activity of muscles on voluntary contraction by the insertion of an electrode needle into the muscle and a ground to the body. Normal readings of muscle activity will show if the muscle and nerve are working properly. If the muscle is receiving no signals from the nerve (is denervated), the muscle will make twitches (called fibrillations) not visible to the eye upon insertion of a needle. *Fibrillations* will show up on an EMG reading and indicate denervation. The EMG will also detect the electrical activity of visible twitches called *fasciculations.* Kambin, Smith, and Hoerner, "Myelography and Myography in Diagnosis of Herniated Intervertebral Disc," 181 *Journal of the American Medical Association* 472, 473-75 (No. 6, August 11, 1962). Crue, Prudenz, Shelden, "Observation on the Value of Clinical Electromyography," 39-A *Journal of Bone and Joint Surgery* 492, 492-94 (No. 3, June 1957).

[4]"All information obtained from the clinical laboratory, as well as from radiographic studies and physical examinations, is of the objective type." On the other hand, "subjective information is that which can be supplied only by the patient himself, for example the feeling of pain or discomfort." Rex B. Conn, M.D. "Interpretation of Laboratory Values," in *2 Current Diagnosis No. 3,* edited by H. Conn and R. Conn (Saunders, 1968).

[5]"The feeling is that these marvelous, complex machines (electro and encephalogram (EEG) and electromyogram (EMG)) in this electronic age, must really produce "objective" data. True, the machines themselves faithfully record squiggles and jogs without error, but *objectivity is lost in the process of translation by the interpreter."* Richard D. Walter, M.D., "Electroencephalography and Electromyography" 1 *Trauma* 25, 44 (No. 1, June 1959)

[6]There are apparently two myelograms in this case. A report of the first myelogram is not contained in the record but there is reference to it in the second myelogram report entitled, "Repeat Myelogram." (App. 164)

whether or not the Respondent was suffering from a herniated disc, or pain, or both.[7]

The results of the repeat myelogram were inconclusive, as contrasted to the hearing examiner's repeated characterization of the tests as negative. (App. 85, 216-17, 224) Such testimony would have indicated that the repeat myelogram was without value as to the question of whether or not the claimant was suffering from a slipped disc or other disabling condition.[8] The significance of the findings themselves, what they mean, may also be unsettled within the medical art. For example, as to the electromyogram, there are differing opinions as to the meaning of particular readings. The "impartial" medical advisor did not point out (App. 220-221) that one type of reading, called a polyphasic potential, which appears on the oscilloscope of the electro-

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[7]A slipped or herniated disc *may* cause an indentation in the fluid sac (subarachnoid space) or it may cause a slight irregularity in the shape of the bulge in the fluid sac where each nerve passes through the sac (the nerve root sleeve) and such an indentation or irregularity would be shown by the myelogram. An electromyogram *may* indicate that a claimant has a slipped or herniated disc by showing some alteration in the function of the muscles which are controlled by the nerve cords passing through the portion of the spinal cavity in which the disc is supposed to be protruding. Changes in a nerve leading to a muscle may under many circumstances result in changes in the electrical properties of that muscle.

In the case of the electromyogram, the readings reflect only the electric potentials of muscles during exercise, and in a myelogram, the readings reflect only shadows of irregularities in the membrane composing the spine. The limited findings described above must be subjected to many levels of interpretation and usage to achieve any diagnostic purpose.

[8]Contrary to the finding of the hearing examiner that the myelograms suggest "no impairment . . . [or] only mild involvement," (App. 224) the findings of the second myelogram are inconclusive. The repeat myelogram indicates that the radio opaque material was in the "subdural space of the lumbar region . . . mass of the opaque media is in the subdural or epidural space." In other words, the fluid was not restricted to the subarachnoid space and no reading could be taken. The repeat myelogram does not comment on the integrity

myogram, is considered by some doctors to be a positive indication of nerve root involvement.[9] The absence of a fibrillation potential, which was deemed by Dr. Leavitt (App. 220-221) to indicate the lack of compression, while other doctors maintain that the absence of fibrillation potentials are not critical to diagnosis of nerve compression, as most compressions do not cause denervation.[10]

2. *The reasons for the limited reliability of the particular testing procedures and the relationship of those reasons to the circumstances of the claimant must be established.*

The EMG is generally regarded as being about 75-80% reliable.[11] The reliability of the EMG findings is affected in part by several factors which may produce "false-negative readings" (an incorrect finding of the lack of any abnor-

or shape of the subarachnoid space because the dye was mistakenly injected in the subdural space. The original myelogram which perhaps showed the surgeon, Dr. Munslow, something to cause him to write a pre-operative diagnosis of "probable protruded interverterable disc" is missing from the record. Subdural injections of the opaque material is one of the more common technical complications of myelography. When this occurs it is best to remove as much of the dye as possible, and repeat the myelogram at a later date. Such a result is "non-contributory," rather than negative. MacCarty and Lane, "Pitfalls in Myelography," 65 *Radiology* 663, 666-667 (November 1955).

[9]Mendelsohn and Sola, "Electromyelography in Herniated Lumbar Discs," 79 *A.M.A. Archives of Neurology and Psychiatry* 142, 143 (February 1958).

[10]Goodgold, letter to editor, 51-A *Journal of Bone and Joint Surgery* 1451 (No. 7, October 1969); The lack of fibrillation after the passage of time could be just as consistent with nerve damage as with the lack of nerve damage. Fibrillation potentials may be difficult to detect after one year. Mayo Clinic, *Clinical Examinations in Neurology* Ch. 17 (2d. ed., 1963)

[11]Dr. Leavitt's testimony, App. 136; Kambin, Jarvis and Hoerner, "Myelography and Myography in Diagnosis of Herniated Intervetebral Disc," 181 *Journal of American Medical Association*, 472, 474 (No. 6, August 11, 1962).

mality when an abnormality in fact exists). In the first place, "a small herniation may compress only the posterior *sensory* nerve. This patient may have some pain without any electromyographic findings because the *motor* nerve is not involved."[12] A second important factor affecting the reliability of the EMG is that false negative readings can be caused by the fact that within any given muscle there are several motor units.[13] And it is possible with a less than complete procedure to test a particular muscle and fail to detect one or more denervated motor units within that muscle.[14]

The attitude of the person being tested can affect EMG readings. "It is . . . necessary to have a co-operative patient as the electrical events during muscle relaxation need to be studied in particular."[15] The fact that Mr. Perales, whose fluency in English was acknowledged as restricted, was distrustful of "Anglo" doctors and was uncomfortable in their presence may have contributed to a false EMG reading. (App. 89). The claimant's discomfort may have been heightened by the painful testing procedures used to obtain EMG readings.[16] Cross examination is needed to establish the importance of these variables, how they affect

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[12]Kambrin, *supra*, n. 11, at p. 474. See also Crue, Prudenz, Sheldon, "Observations on the Value of Clinical Electromyography," 39-A *Journal of Bone and Joint Surgery*, 492, 494 (No. 3, June 1957). The authors state a large disc protrusion could spare the anterior motor root.

[13]The EML only tests the "motor" nerves which control the muscles; the EML does not test the "sensory" nerves and pain could be caused by compression of a sensory nerve. See also, n. 3, supra.

[14]Crue, *supra*, n. 12, at p. 493.

[15]Richard D. Walter, M.D., "Electroencephalography and Electromyography," 1 *Trauma* 25, 41 (No. 1, June 1959).

[16]The introduction of the needle to the skin causes the most discomfort. At least forty different areas of a muscle must be tested before results may be considered as negative. Crue, *supra*, n. 12 at p. 493; Kambin, *supra*, n. 11, at p. 474.

the reliability of the objective test, and their significance to the testing doctor.

3. *No matter how significant and reliable objective findings may be, the findings are only part of the entire process of medical reasoning, and objective findings must be interpreted in light of the entire reasoning process.*

Perhaps the most important function of cross-examination of the doctors who report objective findings would be to explore the relationship of laboratory tests to the overall process of medical reasoning used to reach a diagnosis. Laboratory results are not the exclusive basis upon which a diagnosis is made but are only a means "to extend the physician's power of observation to include quantities not visible, palpable or audible."[17]

The normal process of diagnosis begins with the physician taking a history of the patient's medical problems, recording the symptoms of his present complaint, and then conducting a thorough physical examination. At this point the physician may request laboratory work and perhaps the consultation of specialists. "It is then up to the clinician to evaluate all data and opinions and, together with appropriate consultants, make a final diagnosis, institute treatment, and formulate a tentative prognosis in the light of the diagnosis and probable effectiveness of treatment".[18] This procedure is utilized in the diagnosis and treatment of ruptured or slipped discs.[19]

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[17]Conn, Rex B., M.D., "Interpretation of Laboratory Values," in 2 *Current Diagnosis 3,* Eds. Conn & Conn (Saunders, 1968).

[18]Haas, M.D., "Relationship of Trauma to Injury and Disease: The Pathologist's Approach," 31 *Texas Law Review,* 747, 758 (1953).

[19]Frankel, M.D., LL.B., "Low Back Injuries-The Ruptured Disc Syndrome," 11 *South Carolina Law Review* 171, 174-178 (1958).

The value of objective tests therefore inheres in their proper integration with the patient's history and the results of a complete physical examination. See, Mayo Clinic, *Clinical Examinations in Neurology*, Ch. 17 (2nd ed. 1963). The subjective judgments of the examining physicial are crucial, both in interpreting the objective tests and in integrating his interpretations with all factors present.[20]

The reasoning process of physicians is rarely disclosed in the written reports they submit for disability determinations. Subjective medical conclusions abound. Yet there is no way, without the benefits of cross examination, that one may reliably determine the role played by each of the various factors disclosed during the examination in the conclusions, and the reasoning process used to reach these conclusions.

B. Medical Reports Prepared for Disability Evaluation Purposes, Rather Than for Treatment, Require Close Scrutiny as They May be Based Upon Subjective Judgments Outside the Expertise of the Physician Preparing the Reports.

The reports of consultant physicians also lack reliability and probative value as medical evidence because they are prepared specifically for use in disability determinations. In the case at point, the reports of Drs. Langston, Bailey and Mattson were prepared by them as consultants and Dr. Munslow's reports were prepared for private insurance purposes.

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[20] "The EEG and EMG examinations are quite similar, in terms of objectivity, to the examination of x-ray films. The importance of the training and experience of the electroencephalographer and electromyographer becomes obvious when complexity of the date is appreciated. *The greatest danger to the patient in both EEG and EMG are that the results of the examination will not be considered in the light of all other clinical information.*" Walter, supra, at n. 15, at p. 44. (Emphasis supplied) *See also*, Wiltberger, M.D., "The Medico Legal Aspect of Low Back Pain," 15 *Ohio State Law Journal* 437, 443 (1954).

The reports are therefore not written as objective medical reports, as those used in the normal practice of physicians, but are conceived and written for the purpose of determining disability. As such they are written as substitutes for the testimony which their authors would give before a disability examiner or hearing examiner. As with other testimony a claimant should have the right to cross-examine its creator. The reports may also have been written with a particular legal standard in mind, since the consultants were aware that objective medical evidence dominates disability determinations.

The written medical reports should also not be admitted at hearings as medical evidence because they are used during the hearing to prove matters other than the medical elements of disability. Dr. Langston reported that Perales was "obviously holding back and limiting all of his motions, intentionally," and that there was an "obvious attempt of a patient to exaggerate his difficulties by simply just standing there and not moving . . ." (App. 175 and 177.) The Hearing Examiner used this entirely subjective judgment of Dr. Langston to find that Perales had no medically determinable impairment and also to assess the credibility of Perales as a witness. His decision reads:

> The willful resistence to motion of limb by the claimant on occasion, as indicated in the electromyographic examination, and supported by a prior neurological examination on the part of one of the doctors who examined him is in itself significant. (App. 224.)

Dr. Langston's subjective judgment was therefore used to support a denial of benefits on medical grounds. It was also used in assessing Perales' credibility to diminish the weight given the "subjective recitation of the complaint of the claimant" because "there are inconsistencies" in his testimony "which have not been explained." (App. 224). Thus, purely subjective statements of a doctor describing the state of mind of the claimant, submitted in evidence solely in

written form as opposed to medical conclusions, were strongly relied upon as medically "significant" and used to discount the direct testimony, under oath, of the claimant.

II. THE GOVERNMENT SEEKS IN THIS CASE TO ESTABLISH AN "OBJECTIVE EVIDENCE" STANDARD THAT IS STATUTORILY UNAUTHORIZED, IMPRACTICAL AND HARSH.

The Government contends that in proceedings on claims for Disability Insurance benefits written reports of "objective" tests and examinations should be considered inherently reliable and probative evidence on the issue of disability. This contention arises from the strong emphasis on purely medical evidence in general and so-called "objective" medical evidence in particular throughout the Social Security Administration's consideration of Disability Insurance claims. In this case, the Social Security Administration applied standards requiring "objective" evidence of both the existence and the severity of the impairment. This standard is an improper basis of decision: it conflicts with the statutorily-prescribed functional test of disability and in practical effect places an onerous burden on Disability Insurance claimants. Yet the Government defends the "objective evidence" standard here by urging the inherent reliability and probative value of "objective" medical test reports as substantial evidence.

A. The Government Seeks to Establish a Standard of Objective Evidence.

The procedure followed by the Secretary under the regulations and in this case unduly emphasizes medical and "objective" evidence. The acceptance of written reports of such "objective" evidence at face value, as the Government urges, would lend approval to a substantive "objective" evidence test for disability claims.

The determination of non-disability made in the present case by the State agency[21] and hearing examiner illustrates the restrictive and burdensome effect of the application of the "objective" medical evidence test of disability. The Reconsideration Determination made by the State agency upon request of the claimant states that the medical evidence failed to "reveal any nerve or bone impairment" and that Mr. Perales' "ability to sit, stand and walk" was not seriously impaired. (App. 159) The Determination's conclusionary statement to the effect that the medical evidence fails to demonstrate a loss of function directly contradicts Dr. Morales' findings that the claimant was

> unable to stoop, or, on beinding [sic] over, was unable to bring his outstretched hands closer than about one foot from the floor. Patient was unable to hyperextend or flex the trunk to either side without a subjective complaint of pain. (App. 182).

The requirement of "objective evidence" also entails that the results of only certain "objective" tests are considered by the State agency. Here Dr. Morales' clinical findings of "muscle spasm in lumbo-sacro region of the spine" and "spasm . . . in the region of both sacro-iliac joints" were not considered by the State agency as objective evidence of an impairment (App. 182). The Determination concludes by stating that while Dr. Morales' opinion as to the claimant's inability to work has been considered, "in a case like this where judgments of physicians differ as to the effects of impairments, the decision must be based on the *objective evidence* presented" (App. 159) (Emphasis added).

The Agency's emphasis on "objective evidence" to the exclusion of other medical evidence, the opinion of treating doctors and claimant's own statements of limitation of function and pain, appears in an evaluation report written by Dr. Howard Moses. Dr. Moses reviewed the medical evidence for the State agency on Reconsideration and concluded:

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[21] The Secretary contracts with State agencies, as authorized by 42 U.S.C. § 421, to make initial determinations of disability.

> [A]lthough the claimant has complained of low back pain since an injury in 9-65 and he had surgery performed for reasons not quite apparent from the medical evidence, *he has no objective evidence of severe othopedic or neurological impairment* (App. 190) (Emphasis added.)

The transcript of the hearing and the decision of the hearing examiner in the present case show that he erroneously placed undue weight on "objective" medical evidence. The examiner's analysis of the medical evidence and his questioning of Dr. Morales were directed to establishing the existence of an impairment solely on the basis of "objective" medical evidence. The examiner's concern with objective medical findings is demonstrated by the following statement made during the hearing:

> I have to find out the particular diagnosis based on the medical evidence—what is wrong; and the degree of severity; I have to determine the medical evidence that supports the diagnosis; *I need clinical and pathological objective findings of the physician to support the diagnosis of the impairment* [App. 87]. [Emphasis supplied.]

The application of the objective standard is further illustrated by the fact that during the first hearing the examiner was of the opinion that there was no "objective" medical evidence verifying the existence of claimants' alleged impairment. At one point in the hearing he directed claimant's counsel to furnish a brief on the problem of "objective clinical and pathological findings versus the honest opinion of a family physician that can't put his finger on a particular thing to support his diagnosis . . ." (App. 87). At the second hearing the Medical Advisor reviewed the same evidence that Dr. Morales had analyzed in the first hearing and concluded that the "objective evidence" indicated a back impairment of mild severity (App. 142). The expert's opinion of the severity of claimant's condition was based exclusively on the results of certain objective tests. His opinion was adopted by the hearing examiner and made part of his findings (App. 225).

In his decision the Hearing Examiner considers separately the "subjective . . . evidence" and the "objective" evidence. The Hearing Examiner considered Respondent's description of his functional limitations and his pain to be only "subjective" evidence relevant to "the low back syndrome, with its overlay of emotional involvement." (App. 224) The Hearing Examiner apparently gave very little weight to this evidence because of unexplained "inconsistencies" in the testimony. (App. 224)

The Hearing Examiner summarized the "objective" evidence as:

> two separate myelograms, an operation in which the surgeon was able to visually examine the pathological condition, and a subsequent electromyographic examination. [App. 224]

The Hearing Examiner characterized this evidence as indicating either "no impairment" or "only a mild involvement." (App. 224) Contrary to these findings, however, the record includes the report of only *one* myelogram (entitled "Repeat Myelogram," App. 163). This report itself expresses no conclusion, either positive or negative, as to pathology. See pp. 6-8, supra.

The fallibility and complexity of these tests, see pp 4-13, supra, show the impermissibility, absent cross-examination, of attributing special weight to their interpretation on the basis of their "objectivity." The Hearing Examiner discounted the claimant's testimony as to his pain and functional limitations apparently on the basis of doctor's reports of poor effort or cooperation in the tests. (App. 224)

The Secretary's regulations evidence the same insistence on objective medical evidence. The regulations contemplate the award of disability benefits either on the basis of the existence of an impairment alone or on the basis of a functional evaluation. The regulations spell out the impairments recognized by the Secretary as medically establishing disability *per se*. 20 C.F.R. 404.1502(a). In the nature of

these impairments, such as the loss of several limbs or terminal cancer, they are susceptible of verification by objective diagnosis. Absent such objective evidence, the claimant must show an impairment entailing such limitation of his ability to perform significant functions that he is unable to do his previous work or, considering his age, education and work experience, any kind of substantial gainful work in the national economy. 20 C.F.R. 404.1502(b). In such cases, assuming impairments diagnosed as less severe than those listed by the Secretary, the regulations require the claimant to furnish evidence as to his education, work experience, daily activities before and after onset of disability, and other pertinent facts demonstrating the functional effect of his impairment. 20 C.F.R. 404.1523. This evidence is collected in very summary form in the claimant's application for benefits (Exhibit No. 3), but the regulations provide no guide for its evaluation. Therefore determinations must rely primarily on the medical evidence.

The Government urges approval of this process and a standard of "objective" evidence through a holding that the medical evidence is of inherent reliability and probative value. That principle would authorize the acceptance of all reports of purportedly objective examinations or tests at face value. Such acceptance would allow reports showing negative results to be considered substantial evidence sustaining the denial of claims. The Secretary would thereby gain authority to deny claims merely on the basis of his inferences from–or the lack of–"objective" medical evidence.

B. The Social Security Act Prescribes a Functional Test, Considering All the Evidence, for Disability Determinations.

In 1956 Congress amended the Social Security Act to extend Title II insurance benefits to persons afflicted with disabilities of sufficient severity to prevent their return to gainful employment. 42 USC 401 *et seq.* Through the Disability Insurance program Congress sought to protect

workers against loss of wages, medical expenses and pain, and distress and deformity occasioned by a disabling impairment.

The statutory standard for award of benefits requires that the claimant be physically or mentally impaired and that the impairment vitiate his employability. The impairment must be an impairment of extended duration:

> that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques. [42 USC § 423 (d) (3)]

The claimant's unemployability exists when:

> he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy . . . . [42 USC § 423(d) (2) (A)].

The determination of disability involves consideration of the existence and severity of the claimant's impairment and his ability in fact to function in a real job situation.

The statute requires that the claimant furnish "such medical and other evidence as the Secretary may require", 42 USC § 423 (d) (5), and evidence received is to be considered "even though inadmissible under rules of evidence applicable to court procedure." 42 USC § 405 (a). Under the statute, therefore, the determination of disability requires the sensitive evaluation of lay and technical evidence. The determination must seek a thorough and concrete resolution of the claimant's functional limitations and the demands of particular employment. The denial of a claim may not ordinarily rest on the monistic application of medical expertise. Disability may not properly be administratively simplified by abstraction blurring the concrete features of a claimant's case, or by reduction of the determination to quantitative measurement of localized impairment.

Reviewing courts have consistently held that Section 223(d)(3) of the Act, 42 USC § 423(d) (3), establishes the relevance and value of all medical evidence on the issue of impairment and does not require "objective" medical evidence. In *Flake v. Gardner*, 399 F.2d 532 (9th Cir. 1968), the court stated:

> [W]e doubt that [the amendment] was designed to restrict the medical evidence to "objective" or "physical" symptoms. We used the word "objective" in discussing section 223(d) in *Ryan v. Secretary*, 9 Cir., 1968, 393 F.2d 340. But the statute does not use it. . . .
>
> The statute refers to "medically acceptable clinical * * * diagnostic techniques." Stedman's Medical Dictionary, 20th Ed. defines "clinical" as:
>
> > "2. Denoting the symptoms and course of a disease as distinguished from the laboratory findings of anatomical changes."
>
> We venture to suggest that there may be people who are really disabled, and can be found so by medically acceptable clinical diagnostic techniques, even though laboratory techniques do not support the diagnosis. [399 F.2d at 540.]

See *Mark v. Celebrezze*, 348 F.2d 289, 292-293 (9th Cir. 1965).

A number of appellate courts have held that reversible error is committed if the hearing examiner interprets the Act as requiring the claimant to establish a medical impairment by means of "objective" medical evidence. The Sixth Circuit in *Whitt v. Gardner*, 389 F.2d 906 (1968), held that Section 223(d) (3) does not require the medical evidence to be "objective":

> *The Act nowhere states a requirement that a claimant establish his disability by "objective" medical evidence.* In a case such as the present one, much of the evidence was subjective in nature. Appellant's primary complaint being that of incapacitation because of extreme pain. This Court, as well as others, has considered the infection of an exa-

> miner's findings by such an erroneous legal standard to be reversible error, no matter what our view be as to the correctness of his ultimate conclusion. (Emphasis added.) [389 F.2d at 909].

Accord, Marion v. Gardner, 359 F.2d 175 (8th Cir. 1966); *Page v. Celebrezze,* 311 F.2d 757 (5th Cir. 1963); *Ber v. Celebrezze,* 332 F.2d 293 (2nd. Cir. 1964).

The posture of the courts on this issue arises from a recognition of (1) the limited value of objective medical evidence on the question of a man's ability to work and (2) the fact that disability is not exclusively a medical issue under the Act. 42 USC 423 (d) (2). Reviewing courts have frequently observed that "medicine is a notoriously inexact science" and, therefore, "objective" test results are not necessarily dispositive of the claimant's disability. *Dillon v. Celebrezze,* 345 F.2d 753, 755 (4th Cir. 1965); *Lackey v. Celebrezze,* 349 F.2d 76, 78-79 (4th Cir. 1965); *Stokes v. Finch,* C.C.H. Unempl. Ins. Rep. para. 15,671 (D.S.C., December 3, 1969); *Mark v. Celebrezze, supra; Combs v. Gardner,* 382 F.2d 949, 956 (6th Cir. 1967); *Santagate v. Gardner,* 293 F. Supp. 1284, 1292 (D. Mass. 1968).

The cases considering the factor of pain illustrate the limited value of "objective" tests. Reviewing courts have consistently acknowledged that pain is outside the scope of objective scientific measurement but is nonetheless a crucial factor in a disability determination. See *e.g., Flake v. Gardner, supra; Skeens v. Gardner,* C.C.H. Unempl. Ins. Rep., para. 14,782 (4th Cir., May 12, 1967); *Underwood v. Ribcoff,* 298 F.2d 850 (4th Cir. 1962). Reviewing courts have additionally held that while the clinical opinion of the claimant's treating physician as to the severity of an impairment and its effect on the claimant's ability to function is not conclusive on the issue of disability, it must be accorded substantial weight. *Combs v. Gardner, supra; Heslep v. Celebrezze,* 356 F.2d 891, 894 (4th Cir. 1966); *Celebrezze v. Walter,* 346 F.2d 156 (5th Cir. 1965); *Hayes v. Gardner,* 376 F.2d 517 (4th Cir. 1967).

C. Considerations of Logic and Fairness Weigh Against an "Objective Evidence" Standard.

The requirement of "objective" evidence in support of disability claims is supported by neither logic nor fairness to the claimant. The "objective evidence" standard greatly increases the burden of proof on the claimant. The evidence thus required is not reasonably necessary to the determination to be made.

The value of written reports of "objective" tests or examinations is severely limited by their complexity and fallibility and by the narrow significance of the results. This brief elsewhere discusses the defects of the tests–the myelogram and electromyogram–performed on Respondent. Given such complexity and fallibility in execution, the relevance and weight of the evidence in determining the existence and severity of the impairment must be determined in each case. See pp. 4-13, supra.

Medical reports of objective tests or examinations provide only some evidence on or partial answers to the ultimate question of disability. Such reports should not by any rule of evidence be invested with more value in a substantive decision than what they reasonably may be taken to show about impairment. What they show is a matter of interpretation, relying in turn on judgments of accuracy, and must be determined in each case.

The present practice of relying on objective medical evidence results in placing an unwarranted burden of proof and hardship on disability claimants. Objective medical evidence necessitates costly examination and testing by specialists, the expense of obtaining extensive written reports from specialists, and the need to supply repetitive objective substantiation of the existence of impairments. Congress never intended for claimants to have these expenses in establishing disability.

Claimants usually have difficulty obtaining the extensive objective medical evidence now required to meet their burden of showing disability. Most claimants have few medical

sources, and a substantial number must rely exclusively on their family doctor to furnish medical evidence. Most disability claimants are financially unable to arrange for special examinations by specialists for the sole purpose of furnishing evidence of disability. And even if a claimant has been examined by a specialist in conjunction with his disability, it is frequently difficult and costly to persuade the physician to develop his notes into a comprehensive medical report.

State agencies are not obligated to supplement the medical evidence furnished by a claimant. Consultative examinations at government expense are discretionary and the large number of examinations arranged by the agency in the present case is unusual. The claimant has no power to compel the state agency to have him examined at government expense. Once a state agency determines that an individual is not disabled, it does not authorize additional examinations simply because the claimant is dissatisfied with the determination.

Disability recipients, as well as claimants, are poor.[22] Obviously if recipients are poor, claimants are poorer and lack the financial means to supply the evidence presently required to establish disability. Furthermore, they are likely to be uneducated and elderly. In 1966, 49.3 percent of the workers granted disability benefits had eight years or less of formal education,[23] and 72 percent of them were over age 50.[24] Pedro Perales is poor and has only a third grade education.

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[22] Brehm, Henry P., "The Disabled on Public Assistance," U.S. Department of Health, Education and Welfare, Table 4 (June 1970). The median annual income, in 1966, of the 849,000 disabled worker beneficiaries, was $2,836; 34.7 percent were below the poverty level.

[23] Social Security Administration, U.S. Department of Health, Education and Welfare, *Social Security Disability Applicant Statistics 1966*, Pub. 70-11 (2-7), Table 14, p. 41. (November 1969).

[24] *Ibid.*, Table 2, p. 12.

Consequently, disability claimants face the expense of establishing disability ill-prepared financially and educationally to comply with their heavy burden of supplying objective medical evidence.

Moreover, claimants are rarely represented at pre-hearing stages or at hearings by legal counsel or other qualified representatives. Only 18.9 percent of claimants are represented by attorneys at Social Security Administration hearings while an additional 7.6 percent are represented by persons other than attorneys.[25] The appearance of an attorney or other representative at disability hearings has a marked effect on the claimant's success at the hearing. Reversal rates at hearings where claimants are represented by attorneys are 12 percent higher than at hearings where attorneys are not present.[26] In absolute terms, the reversal rates at all federal disability hearings, for the period July 1965 to September 1969, was 44.2 percent.[27] But, when a claimant appeared alone the reversal rate was 38.8 percent, as contrasted to a 54.0 percent reversal rate when an attorney appeared

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[25]Statistics supplied to counsel by the Social Security Administration's Bureau of Hearings and Appeals. Figures for representation by attorneys and others at Social Security Administration Hearings are for fiscal years 1965 to 1970, the only years for which such figures are available. Figures are for all Social Security Administration programs, and are not available for individual programs. Even so, in fiscal year 1969 there were 27,948 requests for disability hearings as compared to 3,210 requests for retirement hearings, so that the figures are clearly indicative of the result that would obtain if disability hearings were isolated.

[26]Rock, Michael H., "An Evaluation of the SSA Appeals Process," U.S. Department of Health, Education and Welfare, Report No. 7, p. 4 (April 1970). Interestingly, the reversal rate for non-attorney representatives is 10 percent higher than hearings where the claimant is represented by neither an attorney nor a non-attorney representative. These rates are for hearings at which attorneys and non-attorney representatives appeared with claimants along with various combinations of other persons.

[27]*Ibid.*, p. 9.

along with a claimant.[28] Not only does the presence of an attorney at a hearing greatly improve a claimant's chances of success at the hearing, but it also increases the chance that an unfavorable hearing decision will be appealed.[29]

Therefore, although representation at a hearing, and presumably prior to the hearing stage, greatly increases a claimant's success in establishing disability, more than 80 percent of claimants are not represented by attorneys at hearings. Most claimants go without help in dealing with the intricate process of accumulating objective medical evidence, and in understanding the technical aspects of hearing procedures. The construction now placed on the Act's requirements for qualifying for disability, with the dominance of "objective" medical evidence, has distorted the originally intended focus of the disability inquiry. The effect of reducing disability to a purely medical issue, because it is the least complicated method of determining disability, substantially increases a claimant's burden in supplying the proof necessary to demonstrate disability. The result is a procedure which is extremely burdensome to the vast majority of claimants. They are unable to accumulate or present objective medical findings, or to ensure the presence at hearings of doctors responsible for these findings.

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[28] *Ibid.*, p. 10. The 54.0 percent reversal rate is for hearings where only a claimant and his attorney appeared.

[29] *Ibid.*, p. 9. n. 4. 59 percent of the denied hearing cases involving attorneys were appealed to the Appeals Council, as compared to 47 percent of the denials not involving lawyers.

CONCLUSION

For the foregoing reasons, the judgment of the court of appeals should be affirmed.

Respectfully submitted,

HOWARD THORKELSON
THOMAS PLACE
Appalachian Research and Defense Fund
10 College Lane
Prestonsburg, Kentucky 41653

JAMES M. HAVILAND
DAVID E. SULLIVAN
Legal Research for Appalachian Elderly
308 Coal & Coke Building
Bluefield, West Virginia 24701

JONATHAN WEISS
JAMES KRAUS
Center on Social Welfare Policy and Law
401 West 117th Street
New York, New York 10027

Counsel for Amici Curiae